Legal Issues

The Legal Implications of Family Expectations

Dr. B. was an 88-year-old resident of a skilled nursing facility, a highly educated veteran of two wars who had had a successful medical practice until his retirement. He admitted diagnoses included stage 4 metastatic prostate cancer, for which he had refused chemotherapy. He was admitted to the skilled nursing facility for physical and occupational therapy after hip arthroplasty to treat a new diagnosis of osteoporosis at home.

Dr. B. was competent to make decisions, but his daughter and son were very involved in his medical decision-making. His daughter, Ms. L., visited her father every day and took it upon herself to provide her father with ancillary care.

One day, Dr. B. was in his wheelchair. A certified nurse assistant (CNA) asked him if he wanted to return to bed, but Dr. B. refused. The CNA left the room. Approximately a half hour later, a different CNA found Dr. B. on the floor. He had hit his head on the bedframe and suffered a dislocation of the recently repaired hip. He was transferred to a hospital and underwent another hip arthroplasty. Ten days later, Dr. B. died.

Ms. L. and her brother, Mr. B., sued the facility for wrongful death, elder arthroplasty. Ten days later, Dr. B. died. Dr. B. was an 88-year-old resident of a skilled nursing facility for physical and occupational therapy after hip arthroplasty to treat a new diagnosis of osteoporosis at home.

The case was settled, but its terms are confidential. The facts and evidence related to the suit would ever have been filed. The plaintiffs were both well-educated family members and staff. Families need to know to what extent they want to be aware of these communications.

Role of the Clinician

Clinicians must manage polypharmacy, delirium, dementia, falls, osteoporosis, malnutrition, pressure sores, incontinence, and multiple, interacting comorbidities. Attending physicians have ultimate responsibility for the medical care provided to nursing home residents and must write appropriate orders taking all these comorbidities into account.

Clinicians must assess (with the assistance of the nursing staff) behavioral changes, cognition, affect, gait, and overall physical function in order to maintain or improve functional outcomes. This must all occur with the knowledge that the clinicians are not at the facility 24/7. Thus, they must rely heavily on facility nursing staff as their eyes and ears.

Communication is paramount not only between clinicians and nursing staff but also between clinicians and family members, especially when a resident is incompetent. Families need to know what to expect during their loved one’s stay at a facility. Clinicians should ask families to participate in establishing care goals and expectations for the frequency of medical follow-up with their loved one.

Family Involvement, Outcomes

Communication with families is not simply good practice in general; it is required by F tags 151, 152, and 154. Several interventions have been designed to encourage and facilitate more family involvement.

Family Involvement in Care (J. Gerontol. Nurs. 1992;18[7]:19–25). Researchers at the University of Iowa designed the Family Involvement in Care program to include education sessions for families, as well as written agreements between the families and staff on the care of residents. At the end of a 9-month trial, family members reported better communication and indicated that they responded more favorably to family visits. The researchers also found that medications were more likely to be reduced for the residents with family involvement than in others (J. Gerontol. Nurs. 1992;18[7]:19–25).

The partners in care have been critical at times during a nursing facility stay, besides at admission and the end of life, and approach families with sensitivity and compassion, particularly at these difficult times.

Medical Expert Perspective

Unrealistic expectations on the part of our residents and their families are at the root of much dissatisfaction and mistrust. In some situations, they will contribute to legal or regulatory actions.

Some of these bad outcomes can be prevented or reduced with good communication, patient and family education, and empathy. It’s important that we empower and encourage all staff—not just doctors and other clinicians—to communicate realistic goals of care, along with a caring attitude, to our residents. And all clinicians and staff should take care not to make statements critical of other health care providers (inside the institution or elsewhere).

Physicians may not always take the time to communicate important information to our patients and their families, for reasons including fear of unpleasant interactions and our own discomfort discussing a bad prognosis or end-of-life issues.

It’s a great idea for an attending physician to make contact with a new resident’s family (with permission, of course) upon admission and to give them your contact information—and actually be available when called.

These small measures can yield great results in good faith and appreciation. This column highlights the importance of taking the time to discuss diagnoses, prognoses, expectations, and goals so that patients understand their medical condition (to the extent they want to) and to what to reasonably expect.

—Karl Steinberg, MD, CMD, Editor in Chief